WILLIAMSON COUNTY, TENNESSEE

WORKERS COMPENSATION ANTI-FRAUD PLAN

I. Provisions for the prevention, detection and investigation of workers compensation fraud.

Williamson County Government will take all necessary steps to prevent, detect and investigate all forms of workers compensation fraud, including fraud resulting from misrepresentations in the application for coverage, claims fraud, and security of the County's data processing system. Primary responsibility for detection of such fraud will lie with the Williamson County Risk Management Department. However, each department director shall report to Risk Management any information suggesting that an employee within a particular department has committed any form of workers compensation fraud. Supervisors shall also be required to report such information to their department director to be passed on to Risk Management for investigation.

Williamson County's anti-fraud program is based upon having qualified persons involved with the initial investigation and evaluation of claims in order to recognize those claims which contain fraud indicators. When a suspicious claim is detected, a claims examiner will fully evaluate the claim. The initial stages are critical and the early investigation work is coordinated within the Risk Management office.

A claim will be flagged when any fraud indicator is present. These indicators include, but are not limited to:

- Prior claim history (such as a history of reporting subjective injuries);
- Claimant's current work status (such as whether an injured worker is disgruntled, soon-to-resign, or facing imminent termination);
- The circumstances surrounding the accident (such as the accident occurs in an area where an injured employee would not normally be, or the accident is un-witnessed);
- The medical treatment involved (such as the injured worker protests about returning to work and never seems to improve, or the diagnosis is inconsistent with treatment); or
- The claimant's attorney (such as the same doctor/lawyer pair frequently handling this type of injury).

The presence of these fraud indicators does not absolutely establish the presence of fraud, and further investigation into the matter is required in order to determine if fraud does exist. If fraud is suspected and any fraud indicators are discovered, outside investigators may be used where necessary and where authorized by the County Mayor and/or the Risk Management Director.

When a claim is flagged, the examiner should try to determine the facts and assess whether the claimant is attempting to conceal, withhold or misrepresent the facts. Any information that is gained from the investigation is independently verified. The examiner should develop a well-documented record.

Ultimately, the objective of the investigation is to determine whether or not the claimant may be attempting to conceal the facts without unjustly suggesting or accusing him/her of withholding the facts. Prior to denial of a suspected fraudulent claim, the entire file will be objectively reviewed by the County Mayor or a person selected by him/her. An objective balancing of the facts supporting denial with those indicating coverage will be performed. If the investigation indicates a covered loss, without any factors supporting fraud, then the recommendation will be to settle the claim. Only when the facts clearly indicate that fraud has been attempted is any necessary further investigation to be completed and the claim denied.

Claimants will be expected to provide detailed documentation of any loss or injury, to complete all entries to any forms submitted, and to identify third party sources of information, where applicable. If the claimant refuses or claims he/she cannot provide requested information, we will notify the claimant in writing of:

- Information that is required to resolve the claim issues in question.
- What the claimant is expected to do to resolve the issues in question.
- The time limit for providing the required information.

We offer assistance in meeting the requirements given to the claimant. Finally, we request that a third party, who can verify the facts, be identified, and if necessary, attempt to obtain written authorization that will make it possible to obtain information from third parties. In addition, we will attempt to contact third parties to verify the information.

A basic investigation to determine whether the claim is meritorious begins immediately upon receipt of the claim and our goal is to have the file evaluation substantially complete within thirty (30) days. If, however, a decision cannot be made, additional investigations to be performed will be outlined in writing, with specific comments and target dates for the items disclosed to be completed.

The Williamson County Information Systems department has the primary responsibility for insuring the integrity and security of the computerized data processing system, and Risk Management shall have responsibility for insuring the security of the hard copies of all records.

II. Provisions for the education of appropriate employees in fraud detection and specifics of the anti-fraud plan.

The claims examiner, when reviewing submitted claims for payment, is normally the first person to come into contact with a potentially fraudulent claim. Therefore, we strive to give each claims examiner training to adequately identify fraudulent claims during the early stages of a claims process.

Our anti-fraud plan is distributed to all employees on an annual basis along with the Workers Compensation Guidelines generated by Risk Management. Employees may direct questions to their Department head or to the Risk Management Department.

Our claim examiners are trained to obtain as much loss information as possible from a claimant during the initial contacts after the first loss report. Claim examiners are trained to identify fraud indicators as well as several types of insurance fraud, including, but not limited to the following:

1) Workers Compensation Fraud - Our examiners are taught to look for employees who file claims for injuries which have not occurred, medical providers who bill for services not rendered, an injury or incident which are entirely fictitious, or employees who inflate or exaggerate an otherwise legitimate claim.

2) Claimant Fraud - This fraud is found where a claimant who is allegedly totally disabled is captured chopping wood or climbing a ladder to shingle a house.

3) Contrived Injury - This type of fraud is found if the evidence indicates the claimant is not as injured as originally claimed, if the injury did not actually occur at the work place, or if no injury exists.

4) Intervening Impropriety - When an injured employee receives workers compensation the employee is expected to return to work as soon as recovered from the injury, but the employee does not return to the job and is found enjoying the benefits of off the job pay, while he/she works at another location or job.

5) Professional Consultation Exaggeration - Professional consultant exaggeration occurs when any professional, such as a doctor or lawyer misrepresents information. This type of fraud is found when an employee who is injured visits a medical practitioner to treat the injury in order to obtain workers compensation. In some cases the medical practitioner writes an inaccurate medical report or diagnosis. When that happens, the medical practitioner has committed fraud.

6) Medical Provider Fraud - This fraud also involves medical practitioners, and includes unnecessary testing or treatment of injured or non-injured employees by a laboratory or therapy center which is owned in whole or in part by the referring physician. This type of fraud can also involve charging for services that were never provided.

III. Provisions for the hiring of or contracting for fraud investigators.

If we are unable to get a claim resolved quickly, and we determine that additional information is required beyond that submitted by the claimant and his/her medical provider(s), the claim will be referred to a special investigations unit. We provide these fraud investigators by contracting with an investigation service agency.

When a suspected fraudulent claim is recognized the examiner shall take the following actions:

1) Report the suspected claim to the Risk Management Director for discussion and review.
2) If agreed to by the Risk Management Director, refer the claim to an investigative unit.
3) A claim referral form should be used for referral of the claim to the investigative unit.
4) Attend meetings with the investigator as requested for further discussion regarding the claim file.
5) Maintain responsibility for the claim file during the investigative phase.
6) Continue all normal claim handling processes and procedures.
7) Hold settlement until the investigation results and recommendations are received.
8) Advise the investigator immediately upon receipt of any mail, suit papers or complaints relative to the claim investigation and forward copies to the investigator.
9) Forward all additional documentation received as part of the normal claim handling to the investigator.
10) Receive periodic status reports from the investigator on the progress of the investigation.

When a file is closed, it is placed in our closed filing system, which provides for a destruction date of six (6) years after the closing date on the file. If a claim has been referred to a special investigation unit and has resulted in a denial, then the complete claim file is maintained in a locking file cabinet. A normal destruction date is not placed on these files. We maintain all special investigation unit files, both sustained and denied claims, at least through the applicable statute of limitations period and in no case for less than six (6) years.

IV. Provisions for the reporting of insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

All cases of suspected fraud which are substantiated by the initial investigation will be reported, and any information we possess will be furnished and disclosed, to the appropriate law enforcement official or authority, the Department of Commerce and Insurance, and the Department of Labor for investigation and prosecution.

When any law enforcement official or authority, the Department of Commerce and Insurance or Department of Labor and Workforce Development requests information from us for the purpose of detecting, prosecuting or preventing insurance fraud, we will take all reasonable actions to promptly provide the information requested, subject to any legal privilege prohibiting disclosure of such information. Likewise, when we believe that an act violating Tennessee Code Annotated §§ 56-47-103 or 56-47-104 will be, is being, or has been committed; we will furnish and disclose any information in our possession concerning such acts to the appropriate law enforcement official or authority, Department of Commerce and Insurance or Department of Labor, subject to any legal privilege prohibiting disclosure of such information.

The report form that is provided by the Department of Commerce and Insurance for the purpose of reporting such violations will be completed, and the completed forms will be transmitted to either Fraud & Special Investigations of the Department of Commerce and Insurance or to the Fraud Unit of the Department of Labor, dependent upon which type of fraud is being reported.

If the fraud is perpetrated by a medical practitioner or a licensed attorney, we will seek to ensure that the court or prosecutor notifies the appropriate licensing authority in this state of the judgment for appropriate disciplinary action, including revocation of any professional license, and notifies the appropriate licensing authorities in any other jurisdictions where the practitioner is licensed. Also, once notified, we will request the state licensing authority to consider the imposition of any administrative sanctions or license revocations as provided by law against the medical practitioner, and that the state Supreme Court take appropriate action, including, but not limited to, disbarment with respect to any attorney found guilty of violating Tennessee Code Annotated § 56-47-103.

V. Provisions for the pursuance of restitution for financial loss caused by insurance fraud, where such restitution is appropriate.

All cases of fraud will be prosecuted to the full extent allowed by law. In addition to prosecuting an individual, where appropriate, we will pursue restitution from the claimant who filed the fraudulent claim. When a claimant is convicted of insurance fraud by a court of competent jurisdiction, we will turn to that court for the imposition of monetary restitution for any financial loss or damages sustained as a result of the violation, and we will request the court impose penalties pursuant to Tennessee Code Annotated § 56-47-105, to its full extent. Once the court has determined the type of restitution, we will turn to the court to determine the extent and methods of restitution.

If we can show by clear and convincing evidence that a violation was part of a pattern or practice of violations of Tennessee Code Annotated § 56-47-103, then we will seek to recover threefold our economic damages. Any action we might bring for treble damages will be brought within one (1) year of the last to occur of such violations.

The restitution we will pursue shall include, but is not necessarily limited to,

- Return of any profit, benefit, compensation or payment received by the individual convicted of violating Tennessee Code Annotated §§ 56-47-103 or 56-47-104 directly resulting from the violation;
- Reasonable attorneys' fees, related legal expenses, including internal legal expenses and court costs;
- All other economic damages directly resulting from the conviction of violating Tennessee Code Annotated §§ 56-47-103 or 56-47-104;
- Reasonable investigative fees based on a reasonable estimate of the time and expense incurred in the investigation of the violation or violations of Tennessee Code Annotated §§ 56-47-103 or 56-47-104, proven at trial reasonably attributed to investigations and recovery efforts by owners, insurers, insurance professionals, law enforcement and other public authorities;
- Loss of earnings;
- Paid deductible amounts under an insurance policy; and
- Insurer claim payments.

In addition to the restitution, we will seek a penalty as set forth in Tennessee Code Annotated § 56-47-108, of no less than one thousand dollars ($1,000) and no greater than ten thousand dollars ($10,000), for a violation of Tennessee Code Annotated § 56-47-103.

If we file a civil action for a violation of Tennessee Code Annotated §§ 56-47-103 or 56-47-104, the action will be brought within one (1) year of the commission of the last occurrence of the acts constituting such violation, or within one (1) year of the time the plaintiff discovered (or with reasonable diligence could have discovered) such acts, whichever is later.